

My name is Laurie Spahl. I have been a registered nurse for 17 years and working in the ICU for 10 years. My ICU is comprised of medical, surgical, cardiac, and cardiothoracic patient population. I have significant reservations regarding the language that is currently written, particularly Section 8.05 where you state that the staff nurses on the unit shall assess the stability of that patient using the acuity tool to govern when the nurse can receive a 1 or 2 patient assignment. And the way it is written, the acuity tool looks as though it is more important than the nurses' judgment. I feel strongly that this language should be changed to clearly and concisely state that it is the evaluation, assessment, and judgment of the staff nurses working in the unit on a daily basis that is the ultimate factor in determining acuity and stability of the patient and at what point another patient can be safely assigned to that nurse. The tool is there to supplement the judgment of the staff nurse. And once the nurses make that assessment, the law needs to be followed honored by management and the hospital. That is why the assessment must also be included in the patient record. That is the only way to ensure that it cannot be changed after the fact.

I also feel that it is extremely important that my fellow ICU nurses and I be directly involved in the creation and selection of a highly specific acuity tool because of the variety of specialties we take care of. I fear that if we are not, then we will see all ICU patients put at a default 2:1 patient to nurse assignment, even when it is unsafe to do so. At my hospital, we have lost senior nurses due to retirement or they have taken other positions in the hospital- and they have not been replaced. We currently have to be doubled (2:1) with a fresh cabg patient who comes right from the operating room to the ICU. This is not a safe assignment for the patient who has just went through a major operation. We recently had a patient with a ventriculostomy and ICP drain who needed her hemodynamics monitored every 15-30 minutes and yet, she was not singled (1:1). This puts the patient at extreme risk and is very unsafe. These conditions need to be closely identified and assigned as a 1:1 patient assignment. And if the staff nurses are allowed to be a strong, independent voice in creating and selecting the acuity tool, they will be. That is why Section 8.06 must be changed to create a committee that is made up of at least 50% direct care ICU staff nurses. It also needs to be clear in these regulations that whatever Committee the nurses are on that help develop or select the tool, has the final authority to accept or reject the tool. If not, it will be an exercise in futility, as hospital management will be able to disregard any recommendations and pick whatever tool fits their agenda- not the patients. I urge you to change these draft regulations to state that whatever committee is formed in accordance with this law is not just "advisory" and has the final say over the approval- or disapproval- of the acuity tool.

Thank you.